RESET

Department of Labor and Industries

This form must be completed by a Vocational Rehabilitation Counselor who has received a referral from a self-insured employer.
**** ***Counselor is responsible for sending a copy of this form to each vendor*** ****

SELF INSURANCE
TRANSPORTATION COST ENCUMBRANCE

☐ **Original** ☐ **Modification**

Claimant:	Date	Claim Number

Billing Category and Code	Vendor Name Provider No.	Vendor Name Provider No.	Vendor Name Provider No.	Vendor Name Provider No.	Total Funds
Mileage					0.00
Parking					0.00
Bridge & Ferry Tolls					0.00
Commercial Transportation					0.00
Vendor Funds Allocated	$0.00	$0.00	$0.00	$0.00	
Dates of Service	From: To:	From: To:	From: To:	From: To:	
» » » » » » » » » » » »		**Total Transportation Funds Allocated:**			$0.00

Mileage Calculation

Address training site A	Address training site B

1st, Miles in a round trip (Worker's street address to site A by most direct route).			1st, Miles in a round trip (Worker's street address to site B by most direct route).		
2nd, Multiply miles by the actual training days.	x		2nd, Multiply miles by the actual training days.	x	
3rd, Multiply total in line 2 by current reimbursement rate	x		3rd, Multiply total in line 2 by current reimbursement rate	x	
Reimbursement to site A	=	$0.00	Reimbursement to site B	=	$0.00

Total reimbursement requested (Site A+Site B) = $0.00

Company	Phone No.	FAX No.

Assigned Vocational Counselor:	Date	Signature

Employer or Service Representative ☐ Approved ☐ Not Approved	Date	Phone No.	Signature